

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

64400

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u> c. LENGTH OF STAY IN lb <u>90 yrs</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> <span style="float: right;">b. COUNTY <u>Cecil</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Main St.</u>				d. STREET ADDRESS <u>Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Elizabeth</u>		First <u>Elizabeth</u>		Middle <u>Perkins</u>		Last <u>Abrams</u>	
<b>4. DATE OF DEATH</b> Month <u>4</u> Day <u>21</u> Year <u>19 60</u>		<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <u>8-15-1869</u>		<b>9. AGE</b> (In years last birthday) <u>90 yrs.</u>		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>House keeping</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Isaiah Biddle</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah C Pierce</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> (If yes, give war or dates of service)		<b>17. INFORMANT</b> Address <u>Mrs. Leon Demond, North East. R.D. Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>R.C. Dodson</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <u>4-22-60</u>	
<b>EXAMINER'S NAME (Type)</b> <u>R.C. Dodson</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>4-24-60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Methodist Cemetery</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>North East Maryland</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph R. Grant</u>				<b>ADDRESS</b> <u>North East, Maryland</u>		<b>24a. REC'D BY REGISTRAR</b> <u>APR 25 '60</u>	
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kraus</u>				<b>DATE</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSTS: L OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4462

CERTIFICATE OF DEATH

Reg. Dist. No. 44401

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Conowingo Rural		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Conowingo Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION /				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ernest Stephen Alexander				4. DATE OF DEATH April 4 Day Year 60 19			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 31, 1880	
				9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman Ret.		10b. KIND OF BUSINESS OR INDUSTRY Canteen Co.		11. BIRTHPLACE (State or foreign country) Cecil Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stephen Alexander				14. MOTHER'S MAIDEN NAME Elmira Pekoe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 213-18-6031		17. INFORMANT Address Mrs. Helen Alexander Conowingo, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X Carcinoma of Liver and Stomach DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/19, 1959, to 3/30, 1960, that I last saw the deceased alive on 3/30, 1960, and that death occurred at 9:50 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED James L. Johnson M.D. 245 East High Street 4/4/60							
ACTUAL SIGNATURE James L. Johnson M.D. Elkton Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/7/1960		22c. NAME OF CEMETERY OR CREMATORY Trinity Cem.		22d. LOCATION (City, town, or county) (State) Zion Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Thomas E. McMiller				ADDRESS Rising Sun, Md.		24a. REC'D BY REGISTRAR DATE APR 7 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4463

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64402

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newark R.D. 2</u>				c. LENGTH OF STAY IN 1b <u>X</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>107 Jackson Hall School Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>M</u> Last <u>Anderson</u>				4. DATE OF DEATH Month <u>4</u> Day <u>25</u> Year <u>19 60</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-3-1892</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Kibler</u>				14. MOTHER'S MAIDEN NAME <u>Jennie M. Comer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-14-1009B</u>		17. INFORMANT Address <u>Mrs. Wooper Malone, 226 Colonial Ave. Wil. Del.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> 434.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Cardiac Asthma</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> Month, Day, Year <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R. C. Dodson</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>R. C. Dodson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				<u>4-25-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-28-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SILVER BROOK</u>		22d. LOCATION (City, town, or county) (State) <u>WILMINGTON DEL</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Warwick</u>				ADDRESS <u>Newark Delaware</u>		24a. REC'D BY REGISTRAR <u>APR 29 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

4464

64404

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural		c. LENGTH OF STAY IN 1b 10 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Beechwood Home		d. STREET ADDRESS 1 Beechwood Home	
3. NAME OF DECEASED (Type or print) First Henry Middle Forbes Last Coudon		4. DATE OF DEATH Month April Day 28 Year 19 60	
5. SEX male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 20, 1903
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Excavating	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joseph Coudon, of H.		14. MOTHER'S MAIDEN NAME Clarita Dalcour	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or foreign) No		16. SOCIAL SECURITY NO. 219-18-7099	
17. INFORMANT Address Mary D. Coudon, Port Deposit, Md. Rural			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X Coronary Stenosis DUE TO (b) Myocarditis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-11 1960, to 4-28 1960, that (I) (we) last saw the deceased alive on 4-27 1960, and that death occurred at 3 PM, from the causes and on the date stated above.			
22a. SIGNATURE G.H. Richards Jr		22b. DATE SIGNED 4/29/60	
22c. PHYSICIAN'S NAME (Type) G.H. Richards Jr M.D.		22d. ADDRESS Port Deposit, Md.	
23a. BURIAL, CREMATION, or other disposal (Specify) Burial		23b. DATE THEREOF 4-30-1960	
23c. NAME OF CEMETERY OR CREMATORY St. Marks Cemetery		23d. LOCATION (City, town, or county) (State) Perryville, Md. Rural	
24. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson		25a. REC'D BY REGISTRAR MAY 2 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

102409

CERTIFICATE OF DEATH

102409

10





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

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M  
4465  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

64405

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>12yrs.7mo.14days</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>141 South</b>	
3. NAME OF DECEASED (Type or print) First <b>SKYRINE</b> Middle <b>A.</b> Last <b>CROMWELL</b>		4. DATE OF DEATH Month <b>April</b> Day <b>12</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-19-99</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waiter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Cromwell (deceased)</b>		14. MOTHER'S MAIDEN NAME <b>(deceased) Sarah Cromwell (maiden name unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Lorraine Harried, 39 College Creek Terrace, Annapolis, Md. (Cousin)</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, right lower lobe</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>491X</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>XX</del> (this hospital) attended the deceased from <b>August 29, 1947</b> to <b>April 12, 1960</b> and that death occurred on <b>4:45pm</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>J. H. HOOPER</b>		22b. DATE SIGNED <b>4-14-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. H. HOOPER</b>		22d. ADDRESS <b>V.A. Hospital, Perry Point, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE THEREOF <b>4/19/1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Unknown National</b>		23d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b>		24b. ADDRESS <b>Havre de Grace, Md.</b>	
25a. REC'D BY REGISTRAR <b>DATE APR 22 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

STATE DEPARTMENT OF HEALTH  
CENTRAL AIR-CONDITIONING

UNIT 1  
127th. Ave. 100th St.  
101st Street

101st Street  
101st Street

101st Street  
101st Street

101st Street  
101st Street

101st Street  
101st Street

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101st Street  
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101st Street  
101st Street

101st Street  
101st Street

## CERTIFICATE OF DEATH

64406

Reg. Dist. No.

4450

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>9 d.</u>			
d. NAME OF HOSPITAL (If nat in hospital, give street address) OR INSTITUTION <u>Union</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>B</u> Last <u>Draper</u>				4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-13-1885</u>	
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u> Hours <u>19</u> Min. <u>10</u>		IF UNDER 24 HRS. Months <u>7</u> Days <u>10</u> Hours <u>19</u> Min. <u>10</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>American Leg. Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William H. Draper</u>				14. MOTHER'S MAIDEN NAME <u>Olivia Rigley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u> <u>WWI</u>				16. SOCIAL SECURITY NO. <u>222-03-3775</u>			
INFORMANT <u>Lucy Draper wife</u>				Address <u>RD#1 Elkton</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease with Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Failure</u> DUE TO (c) <u>Failure</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe anemia, cause unknown, (a) Diabetes Mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 2, 1960</u> , to <u>April 10, 1960</u> , that I last saw the deceased alive on <u>April 9, 1960</u> , and that death occurred at <u>3:45 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Tillman D. Johnson</u> M.D.				ADDRESS (Street, city or town, state) <u>123 Sengerly Ave</u>			
PHYSICIAN'S NAME (Type) <u>Tillman D. Johnson MD</u>				DATE SIGNED <u>Elkton, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-13-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gilpin Manor Mem. Pk. Nr. Elkton,</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald M. Dee</u> ADDRESS <u>Elkton, Md.</u>				24a. REC'D BY REGISTRAR <u>APR 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

420.0

1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 4466 CERTIFICATE OF DEATH 64407

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 25yrs.3mo.6days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 3060 - 16th Street, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARK Middle F. Last FINLEY				4. DATE OF DEATH Month April Day 28 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-11-89		9. AGE (In years last birthday) yrs. 70	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mark F. Finley (deceased)				14. MOTHER'S MAIDEN NAME Mary McNeal (deceased)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I unknown		17. INFORMANT Albuquerque, N.M. John Finley, Brother, 4101 Marble Ave. N.E.			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).}						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Bronchopneumonia, bilateral, lower lobes, unresolved						4-5 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease						unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from January 22, 1935, to April 28, 1960, and that death occurred at 6:20am from the causes and on the date stated above.							
22a. SIGNATURE J. L. Garey				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-29-60	
22c. PHYSICIAN'S NAME (Type) J. L. GAREY, Clinical Pathologist, V.A. Hospital, Perry Point, Md.				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 7/29/60		23c. NAME OF CEMETERY OR CREMATORY Rock Creek		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son. Havre de Grace, Md.				25a. REC'D BY REGISTRAR DATE MAY 2 '60		25b. REGISTRAR'S SIGNATURE	





4467

## CERTIFICATE OF DEATH

64408

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD.</b> b. COUNTY <b>CECIL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RISING SUN, RURAL</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		/d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>ELIZABETH</b> Last <b>FLETCHER</b>		4. DATE OF DEATH Month <b>4/</b> Day <b>21</b> Year <b>19 60</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/ 16/ 1872</b>
9. AGE (In years lost birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE RET.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>CECIL CO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM T. JOHNSON</b>		14. MOTHER'S MAIDEN NAME <b>RACHEL H. KIRK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MISS. HILDA DINSMORE</b>		Address <b>RISING SUN, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac decompensation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic heart disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>5 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>3/10</b> , 18 <b>89</b> , to <b>4/21</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>4/21</b> , 19 <b>60</b> , and that death occurred at <b>10 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Neil Taylor J.</b>		ADDRESS (Street, city or town, state) <b>Rising Sun, Md.</b>	
DATE SIGNED <b>4/22/60</b>			
PHYSICIAN'S NAME (Type) <b>Lemon E. McMiller</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4/ 24/ 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>HOPEWELL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>PORT DEPOSIT MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lemon E. McMiller</b>		ADDRESS <b>RISING SUN, MD.</b>	
24a. REC'D BY REGISTRAR <b>APR 25 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4451

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>30 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <u>308 Elkton Blvd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>W.</u> Last <u>Gillespie</u>		4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 9, 1899</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months <u>60</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad-Signalman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Perryville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph E. Gillespie</u>		14. MOTHER'S MAIDEN NAME <u>Effie Boulden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>717-07-5325</u>	
17. INFORMANT <u>Mrs. Anne Racine Gillespie, Elkton, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> 5 minutes DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 15, 1958</u> , to <u>Apr. 13, 1960</u> , that I last saw the deceased alive on <u>Apr. 10, 1960</u> , and that death occurred at <u>4:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>233 E. Main Street</u> DATE SIGNED <u>4/13/60</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>S. RALPH ANDREWS, JR., M.D.</u> PHYSICIAN'S NAME (Type) <u>Elkton, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 16, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>North East Meth. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>North East Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
ADDRESS <u>Elkton, Md.</u>		DATE <u>Apr 22 '60</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 4452 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04410  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton R.D. 1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Verl</b> Middle <b>Kenneth</b> Last <b>Head</b>		4. DATE OF DEATH Month <b>4</b> Day <b>1</b> Year <b>19 60</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-14-1928</b>
9. AGE (In years last birthday) <b>31</b> yrs.		10. IF UNDER 1 YEAR Months <b>31</b> Days <b>1</b> Hours <b>1</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Bread</b>	
11c. BIRTHPLACE (State or foreign country) <b>Wilder Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charlie Edgar Head</b>		14. MOTHER'S MAIDEN NAME <b>Josie Bell Southerland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Zelma Head, Elkton, R.D.1. Md.</b>	
17. INFORMANT <b>Zelma Head, Elkton, R.D.1. Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushed chest Fractured Neck Abrasion</b> 816X DUE TO <b>Both knees and chest Lacerated scalp left side. Possible fracture left femur</b> Conditions, if any, which gave rise to immediate cause (b) <b>side. Possible fracture left femur</b> (c) <b>side. Possible fracture left femur</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Two car collision</b>	
20c. TIME OF INJURY Month, Day, Year <b>7.20 P.M. 4 1 19 60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 272</b>		20f. (City or town) (County) (State) <b>North East Cecil Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>R.C. Dodson</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>		DATE SIGNED <b>4-4-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-4-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>North East Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>North East Cecil Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>GRANT FUNERAL HOME</b>		24a. REC'D BY REGISTRAR <b>4-4-60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED Charles Edgar Head		2. SEX Male		3. AGE 35	
4. OCCUPATION Police Officer		5. MARITAL STATUS Married		6. PLACE OF BIRTH Baltimore, Md.	
7. DATE OF DEATH 1-1-1938		8. TIME OF DEATH 10:30 AM		9. PLACE OF DEATH Home	
10. CAUSE OF DEATH Myocardial Infarction		11. MANNER OF DEATH Natural		12. SIGNATURE OF EXAMINER J. Edgar Hoover	
13. SIGNATURE OF NEXT OF KIN Mrs. E. Head		14. SIGNATURE OF PHYSICIAN Dr. J. Head		15. SIGNATURE OF BURIAL OFFICIAL Rev. J. Head	
16. SIGNATURE OF WITNESS J. Head		17. SIGNATURE OF WITNESS J. Head		18. SIGNATURE OF WITNESS J. Head	
19. SIGNATURE OF WITNESS J. Head		20. SIGNATURE OF WITNESS J. Head		21. SIGNATURE OF WITNESS J. Head	
22. SIGNATURE OF WITNESS J. Head		23. SIGNATURE OF WITNESS J. Head		24. SIGNATURE OF WITNESS J. Head	
25. SIGNATURE OF WITNESS J. Head		26. SIGNATURE OF WITNESS J. Head		27. SIGNATURE OF WITNESS J. Head	
28. SIGNATURE OF WITNESS J. Head		29. SIGNATURE OF WITNESS J. Head		30. SIGNATURE OF WITNESS J. Head	
31. SIGNATURE OF WITNESS J. Head		32. SIGNATURE OF WITNESS J. Head		33. SIGNATURE OF WITNESS J. Head	
34. SIGNATURE OF WITNESS J. Head		35. SIGNATURE OF WITNESS J. Head		36. SIGNATURE OF WITNESS J. Head	
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70. SIGNATURE OF WITNESS J. Head		71. SIGNATURE OF WITNESS J. Head		72. SIGNATURE OF WITNESS J. Head	
73. SIGNATURE OF WITNESS J. Head		74. SIGNATURE OF WITNESS J. Head		75. SIGNATURE OF WITNESS J. Head	
76. SIGNATURE OF WITNESS J. Head		77. SIGNATURE OF WITNESS J. Head		78. SIGNATURE OF WITNESS J. Head	
79. SIGNATURE OF WITNESS J. Head		80. SIGNATURE OF WITNESS J. Head		81. SIGNATURE OF WITNESS J. Head	
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85. SIGNATURE OF WITNESS J. Head		86. SIGNATURE OF WITNESS J. Head		87. SIGNATURE OF WITNESS J. Head	
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94. SIGNATURE OF WITNESS J. Head		95. SIGNATURE OF WITNESS J. Head		96. SIGNATURE OF WITNESS J. Head	
97. SIGNATURE OF WITNESS J. Head		98. SIGNATURE OF WITNESS J. Head		99. SIGNATURE OF WITNESS J. Head	
100. SIGNATURE OF WITNESS J. Head		101. SIGNATURE OF WITNESS J. Head		102. SIGNATURE OF WITNESS J. Head	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4468

## CERTIFICATE OF DEATH

Reg. Dist. No.

64411

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> (Rural)		c. LENGTH OF STAY IN 1b <u>X</u> <u>Elkton R.D. 3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Merris D. Hicks</u>		4. DATE OF DEATH Month Day Year <u>April 1, 19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 7, 1881</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Paper</u>	
11c. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>William J. Hicks</u>		14. MOTHER'S MAIDEN NAME <u>Cornelia T. Steele</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-05-3985</u>	
17. INFORMANT <u>Mrs. Bertha V. Hicks, Elkton, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/24/60</u> to <u>April 1, 1960</u> , that I last saw the deceased alive on <u>3/24/60</u> , and that death occurred at <u>10:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Elkton, Md.</u> <u>4/5/60</u> ACTUAL SIGNATURE <u>Jacob J. R. Hennwald</u> M.D. PHYSICIAN'S NAME (Type) <u>Jacob J. R. Hennwald</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/5/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Lewisville, Cecil Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>		ADDRESS <u>Elkton, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 12 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

CERTIFICATE OF DEATH

420.1



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<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. RACE</p>		<p>9. RELIGION</p>		<p>10. EDUCATION</p>		<p>11. SOCIAL SECURITY NUMBER</p>		<p>12. MANNER OF DEATH</p>	
<p>13. CAUSE OF DEATH</p>		<p>14. PLACE OF DEATH</p>		<p>15. TIME OF DEATH</p>		<p>16. SIGNATURE OF PHYSICIAN</p>		<p>17. SIGNATURE OF REGISTRAR</p>		<p>18. DATE OF DEATH</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4469  
CERTIFICATE OF DEATH

64412

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>13yrs 1 day</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 3V01.4
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>729 Reservoir Street</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>T.</b> Last <b>HIGGINS</b>		4. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-30-1887</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	11. BIRTHPLACE (State or foreign country) <b>Georgia</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>WILLIAM T. HIGGINS, SR.</b>	
14. MOTHER'S MAIDEN NAME <b>JULIA STOCKTON RUSH</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	
16. SOCIAL SECURITY NO. <b>WW-1</b>		17. INFORMANT <b>Cleo Johnson, Daughter, 729 Reservoir St., Baltimore, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Embolism of pulmonary artery due to venous stasis and thrombosis</b> DUE TO (b) <b>Thrombophlebitis right femoral vein</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>15-20 min.</b> <b>unknown</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>April 18, 1960, 8:15PM</b> to <b>April 19, 1960</b> , that (I) (we) last saw the deceased alive on <b>April 19, 1960</b> , and that death occurred at <b>8:15PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>J. L. Garey</b>		22b. DATE SIGNED <b>4-21-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. L. GAREY, Clinical Pathologist</b>		22d. ADDRESS <b>V.A. Hospital, Perry Point, Md.</b>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE THEREOF <b>4/22/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>PENNINGTON &amp; SON</b>		25a. REC'D BY REGISTRAR <b>APR 27 '60</b>	
ADDRESS <b>Havre DeGrace, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the Certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04413										
4470 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Item 9 FilmG261 4-22-60 et										
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Cecil					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Principio Rural			c. LENGTH OF STAY IN 1b 10 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Principio Rural					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS 1			e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last James Price Howell					4. DATE OF DEATH Month Day Year 4 9 1960					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-28-96		9. AGE (In years last birthday) 65 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frederalburg, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Price Howell					14. MOTHER'S MAIDEN NAME Emma Boyer					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 218-07-0052		17. INFORMANT Address Margaret Howell. Principio Fur. Md						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastric Hemorrhage 784.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE R.C. Dodson					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED 4-10-60
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 15, 1960		22c. NAME OF CEMETERY OR CREMATORY Bethel Methodist		22d. LOCATION (City, town, or county) North East, Cecil Co. Md				
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant					ADDRESS North East Md		24a. REC'D BY REGISTRAR DATE APR 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krays	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED John Doe		AGE 45	
SEX Male		DATE OF DEATH 10-15-1910	
PLACE OF DEATH Home		CITY Boston	
COUNTY Suffolk		STATE Massachusetts	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease	
DISEASE OR INJURY Myocardial Infarction		MEDICAL HISTORY Hypertension	
PREVIOUS ILLNESS None		TREATMENT None	
SIGNATURE OF EXAMINER Dr. J. A. Smith		DATE 10-15-1910	
OFFICE OF THE MEDICAL EXAMINER BOSTON		FILING OFFICE BOSTON	



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 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

64414

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write <b>Port Deposit, Rural</b> )				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cokesbury</b>				e. STREET ADDRESS <b>Cokesbury</b>			
3. NAME OF DECEASED (Type or print) <b>Elijah Westley Hughes</b>				4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 23, 1877</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months <b>82</b> Days <b>82</b> Hours <b>82</b> Min. <b>82</b>		IF UNDER 24 HRS. Months <b>82</b> Days <b>82</b> Hours <b>82</b> Min. <b>82</b>		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Day</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>George Hughes</b>				14. MOTHER'S MAIDEN NAME <b>Mary Eliza Kell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b></b>			
17. INFORMANT Address <b>Mary Hughes, Port Deposit, Md. Rural</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Sclerosis</b> 3344X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-Sclerosis -</b> DUE TO (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b> INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b> <b>10 yrs.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 20, 1959</b> to <b>March 31, 1960</b> , that (I) (we) lost saw the deceased alive on <b>March 31, 1960</b> , and that death occurred at <b>7:30 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Clarence I. Benson</b>				22b. DATE <b>4/2/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Clarence I. Benson, M.D.</b>				22d. ADDRESS <b>Port Deposit, Md.</b>			
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-3-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cokesbury Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md. Rural</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. A. Patterson &amp; Son</b>				ADDRESS <b>Perryville, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 5 '60</b>	
						25b. REGISTRAR'S SIGNATURE <b>Charles S. Harris</b>	

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THE STATE OF NEW YORK  
IN SENATE  
JANUARY 11, 1921.  
REPORT  
OF THE  
COMMISSIONER OF THE  
CORRECTIONAL INSTITUTION  
FOR THE YEAR  
1920.  
ALBANY:  
J. B. LEECH, STATE PRINTER.  
1921.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

4472 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

64415

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun		c. LENGTH OF STAY IN 1b 18 yrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rising Sun		d. STREET ADDRESS Haines Ave	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Edwin Lawrence		4. DATE OF DEATH Month 4 Day 11 Year 19 60	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-5-1899
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bank President		10b. KIND OF BUSINESS OR INDUSTRY Banking	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George A. Lawrence		14. MOTHER'S MAIDEN NAME Rachel A Hitchens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 217-16-3628	
17. INFORMANT Mary Lawrence, Rising Sun, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 977X Laceration of both wrists and Throat DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Lacerated his throat and both arms self inflicted	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dodson		DATE SIGNED 4-12-60	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-14-60	
22c. NAME OF CEMETERY OR CREMATORY Brookview Cem.		22d. LOCATION (City, town, or county) (State) Rising Sun, Md. Cecil Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Thomas M. Muller		24. REC'D BY REGISTRAR DATE APR 14 '60	
ADDRESS Rising Sun Md.		24b. REGISTRAR'S SIGNATURE Cecil E. Kiser	

977X

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death	
John Doe		Male		45		1-1-1920		New York City		123 Main St		Heart Disease		Natural	
Occupation		Education		Marital Status		Social Security No.		Hospital Name		Physician Name		Coroner Name		Date of Death	
Teacher		High School		Married		123-456789		St. Mary's		Dr. Smith		Mr. Jones		1-15-1965	
Time of Death		Place of Death		Time of Discovery		Discovery By		Witnesses		Remarks		Signature of Examiner		Signature of Coroner	
10:00 AM		Home		11:00 AM		Neighbor		John Doe, Jane Doe		No other persons present		[Signature]		[Signature]	

## CERTIFICATE OF DEATH

64416  
Reg. Dist. No.

4461

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Port Deposit</i>		c. LENGTH OF STAY IN TB <i>10 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Francis</i> Middle <i>King</i> Last <i>Markline</i>		4. DATE OF DEATH Month <i>April</i> Day <i>8</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 28 1890</i>
9. AGE (In years last birthday) <i>69</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or last) <i>U.S. mail carrier</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Postal Dept.</i>	11. BIRTHPLACE (State or foreign country) <i>White Hall, Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Philip Markline</i>	
14. MOTHER'S MAIDEN NAME <i>Margaret King</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>	
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mrs. Jessie Markline</i> Address <i>Port Deposit, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Squamous cell carcinoma of neck</i> 199.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>—</i> DUE TO (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>8/1</i> , 19 <i>59</i> , to <i>4/8</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>4/7</i> , 19 <i>60</i> , and that death occurred at <i>3 A</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Neil Taylor Jr.</i> M.D.		DATE SIGNED <i>4/8/60</i>	
PHYSICIAN'S NAME (Type) <i>Neil Taylor Jr. MD</i>		<i>Rising Sun, Md.</i>	
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/11/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Vernon</i>	22d. LOCATION (City, town, or county) (State) <i>White Hall Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles E. Kurtz</i> ADDRESS <i>Garrettsville</i>		24a. REC'D BY REGISTRAR <i>APR 11 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Charles E. Kurtz</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JOHN R. ALLEN

1941

CERTIFICATE OF DEATH

1941





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <u>Cowen Town</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cowen Town</u>		c. LENGTH OF STAY IN 1b <u>2 Mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cowen Town</u>		d. STREET ADDRESS <u>Rock Hall</u>	
3. NAME OF DECEASED (Type or print) First <u>Emily</u> Middle <u>D</u> Last <u>Mench</u>		4. DATE OF DEATH Month <u>Apr</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 20 1881</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clossie D. Kelly</u>		14. MOTHER'S MAIDEN NAME <u>Emma S. Roberts</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Clossie J. G. Mench - Cowen Town Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anemia</u> <u>180X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Malnutrition</u> DUE TO (c) <u>Cancer of Kidney</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>1 yr</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 6</u> , 19 <u>60</u> , to <u>Apr 8</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Apr 6</u> , 19 <u>60</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph S. Lanzi</u> M.D.		ADDRESS (Street, city or town, state) <u>205 W Main St</u>	
PHYSICIAN'S NAME (Type) <u>Joseph G. Lanzi</u>		DATE SIGNED <u>4/8/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/10/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Rock Hall Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Agnes L. Lane</u> ADDRESS <u>6th St. Hill, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 13 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Knecht</u>			

1807

## 4449 CERTIFICATE OF DEATH

64418

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>				c. LENGTH OF STAY IN 1b <u>LIFE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Morgan Nursing Home, City</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ida GERTRUDE Norman</u>				4. DATE OF DEATH Month Day Year <u>April 4 1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 28, 1880</u>		9. AGE (In years lost birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LEWIS B. JEFFRIES</u>				14. MOTHER'S MAIDEN NAME <u>SARAH E. HEATH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (es. no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>180-24-5561</u>		INFORMANT <u>MISS NELLIE NORMAN</u>		Address <u>ELKTON, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis, multiple</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Arteriosclerosis, generalised, severe</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>over 20 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 2, 1960</u> to <u>April 4, 1960</u> , that I last saw the deceased alive on <u>April 3, 1960</u> , and that death occurred at <u>8:12 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Tillman D. Johnson</u> M.D.				ADDRESS (Street, city or town, state) <u>123 Singlerly Ave</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Tillman D. Johnson</u>				<u>Elkton, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/7/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NORTH EAST CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>NORTH EAST, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>GRANT FUNERAL HOME</u> ADDRESS <u>NORTH EAST, MARYLAND</u>				24a. REC'D BY REGISTRAR DATE <u>APR 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1

## 4474 CERTIFICATE OF DEATH

64419  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>2 mo. 1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>M.</b> Last <b>PEEL</b>		4. DATE OF DEATH Month <b>April</b> Day <b>18</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-30-84</b>
9. AGE (In years lost birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles A. Peel (deceased)</b>		14. MOTHER'S MAIDEN NAME <b>Harriett L. Mulford (deceased)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Madeleine Peel, wife, 2317 Blue Ridge Ave.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar pneumonia, right lower lobe</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>unknown</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, generalized, severe</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>VA</b> Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 17, 19 60</b> to <b>April 18, 1960</b> and that death occurred at <b>9:00 a.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>4-19-60</b>			
ACTUAL SIGNATURE <b>J. L. Garey</b>		PHYSICIAN'S NAME (Type) <b>J. L. GAREY</b> <b>Clinical Pathologist</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>4/30/60</b>	
22c. NAME OF CEMETERY OR CREMATOR <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b>		ADDRESS <b>Havre de Grace, Md.</b>	
24a. REC'D BY REGISTRAR <b>APR 22 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
Silver Spring		April 18, 1960	
Place of Birth		Date of Birth	
Silver Spring, Md.		April 18, 1960	
Cause of Death		Date of Death	
Heart Disease		April 18, 1960	
Place of Death		Date of Death	
Silver Spring, Md.		April 18, 1960	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	
Printed Name of Physician		Printed Name of Registrar	
[Name]		[Name]	
Address of Physician		Address of Registrar	
[Address]		[Address]	
City		City	
State		State	
Zip		Zip	



4453

CERTIFICATE OF DEATH

64420

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chesapeake City Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle W Last Rea				4. DATE OF DEATH Month April Day 21 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 29, 1897	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane machine operator		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Rea				14. MOTHER'S MAIDEN NAME No RECORD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-03-5340		INFORMANT John Nelson Rea		Address Charlestown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO Cirrhosis of the liver with ascites Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 7, 1960, April 21, 1960, that I last saw the deceased alive on April 20, 1960, and that death occurred at 2:25 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE S. RALPH ANDREWS, JR., M.D.				ADDRESS (Street, city or town, state) 233 E. Main Street Elkton, Maryland DATE 4/21/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-23-60		22c. NAME OF CEMETERY OR CREMATORY North East Methodist Cem.		22d. LOCATION (City, town, or county) (State) North East Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R Grant				ADDRESS North East, Maryland.		24a. REC'D BY REGISTRAR DATE APR 25 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

THIS IS TO CERTIFY THAT the within and foregoing is a true and correct copy of the original as the same appears in the records of the Registrar of the County of [ ] State of [ ]

Witness my hand and the seal of said County, this [ ] day of [ ] 1953.

Registrar of the County of [ ] State of [ ]

Subscribed and sworn to before me this [ ] day of [ ] 1953.

Notary Public for the State of [ ]

My commission expires on the [ ] day of [ ] 1953.

Attest: [ ]

County Clerk

My office is located at [ ]

City of [ ] State of [ ]

My term of office begins on the [ ] day of [ ] 1953.

My term of office ends on the [ ] day of [ ] 1953.

My office is located at [ ]

City of [ ] State of [ ]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

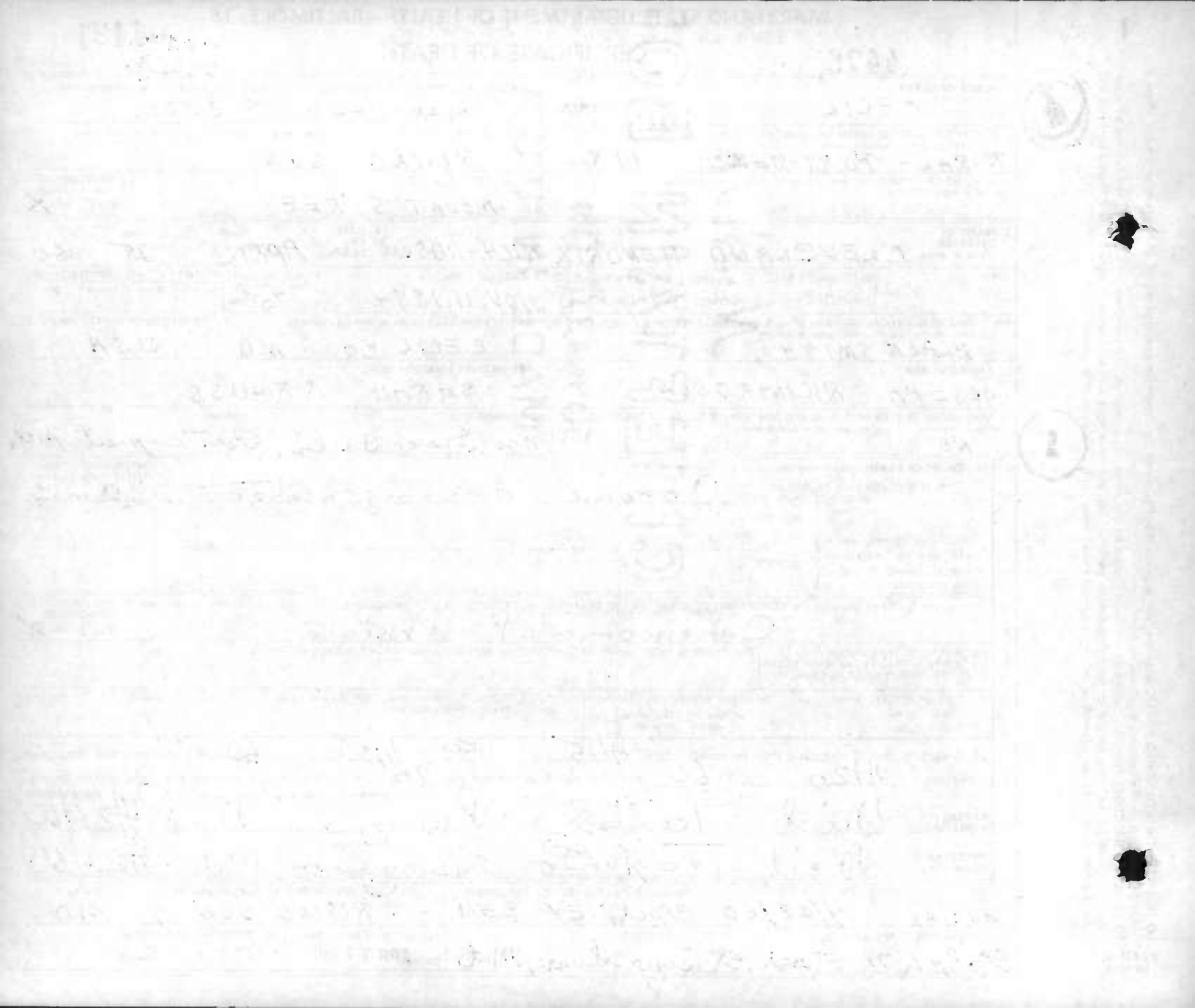
Item 16 Film G261 4/28/60 iwk  
 4476 CERTIFICATE OF DEATH Items 5, 6 & 7 Film G262 5/4/60 iwk

64421

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CECIL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - PORT DEPOSIT 1 YR</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X RISING SUN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CLEVELAND HENDRIX RICHARDSON</b>		4. DATE OF DEATH Month Day Year <b>APRIL 25 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 11, 1884</b>
9. AGE (In years last birthday) <b>75 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BLACK SMITH</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CECIL CO. MD</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOSEPH RICHARDSON</b>		14. MOTHER'S MAIDEN NAME <b>SARAH KRAUSS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-10-9947</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac decompensation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiac decompensation</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of Prostate</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/15</b> , 19 <b>59</b> , to <b>4/25</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>4/25</b> , 19 <b>60</b> , and that death occurred at <b>7 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Neil Taylor</b> M.D.		ADDRESS (Street, city or town, state) <b>Rising Sun, Md</b> DATE SIGNED <b>4/26/60</b>	
PHYSICIAN'S NAME (Type) <b>Neil Taylor</b>		<b>Rising Sun, Md</b> <b>4/26/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4/28/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>BROOKVIEW CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>RISING SUN MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph M Reed, Rising Sun, Md</b>		24a. REC'D BY REGISTRAR DATE <b>APR 27 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kraus</b>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 & 2 should be filed with the funeral director.

VR A15 (4)  
15M 9/59

U.S. DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>17yrs.10mo.25days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>1466 Columbia Road, N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>SOLOMON</b> Middle <b>C.</b> Last <b>ROCKFIELD</b>		4. DATE OF DEATH Month <b>April</b> Day <b>30</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-25-94</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Drug</b>	11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Samuel Rockfield (Deceased)</b>		14. MOTHER'S MAIDEN NAME <b>Clara Kauffman (Deceased)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW-I unknown</b>	
17. INFORMANT <b>Sharon Heights, Ohio</b>		<b>Louise Dubin, Sister, 3440 Avalon Road,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, unresolved</b> 410.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7-10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>June 5 1942</b> to <b>April 30 1960</b> , and that death occurred at <b>5:40PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>J. L. Garey</b>		22b. DATE SIGNED <b>5-2-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. L. GAREY, Clinical Pathologist, V.A. Hospital, Perry Point, Md.</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE THEREOF <b>5/3/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 9 1960</b>	
ADDRESS <b>Havre de Grace, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

64423

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. LENGTH OF STAY IN 1b 11 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert First Clement Middle Ryan Last		4. DATE OF DEATH Month April Day 16 Year 1960	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ? 1884
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during past year, or if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY General Construction. Md.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William T. Ryan		14. MOTHER'S MAIDEN NAME Eliza Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT George B. Taylor, Perryville, Md. Rural		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416 X PNEUMONIA & UREMIA DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. RHEUMATIC HEART DISEASE DUE TO PROGRESSIVE DEFORMANT RHEUMATOID ARTHRITIS		INTERVAL BETWEEN ONSET AND DEATH 15 days years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) G. A. S. & A. S. C. V. D		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 5, 1960, to April 16, 1960, that (I) (we) last saw the deceased alive on April 15, 1960, and that death occurred at 6:15 AM, from the causes and on the date stated above.			
22a. SIGNATURE Luis M. Cuza		22b. DATE SIGNED 4-19-60	
22c. PHYSICIAN'S NAME (Type) LUIS M. CUZA		22d. ADDRESS Cecil Ave. North East, Md	
23a. BURIAL, CREMATION, or other disposition (Specify) Buried		23b. DATE THEREOF 4-20-1960	
23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		23d. LOCATION (City, town, or county) (State) Port Deposit, Md Rural	
24. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson, Son		ADDRESS Perryville, Md.	
25a. REC'D BY REGISTRAR DATE APR 20 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

11111

CERTIFICATE OF DEATH

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4455

## CERTIFICATE OF DEATH

64424

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Earlville, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hosp.</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Stephen</u> Last <u>Somers</u>				4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 13, 1896</u>	
9. AGE (In years lost birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dodge Steel Found.</u>		11. BIRTHPLACE (State or foreign country) <u>Chester, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles F. Sakers</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Cannon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1927</u>				16. SOCIAL SECURITY NO. <u>165-05-6709</u>			
INFORMANT Address <u>Mrs. Martha Sakers, Earlville, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>527.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Emphysema</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease &amp; Cong. Failure.</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>January, 1959</u> to <u>1 April, 1960</u> that I last saw the deceased alive on <u>1 April, 1960</u> , and that death occurred at <u>8:00</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Wallace Obenshain, M.D., Cecilton, Md.</u> DATE SIGNED <u>1 Apr 60</u>							
ACTUAL SIGNATURE <u>Wallace Obenshain</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Wallace Obenshain, M.D.</u> <u>Cecilton, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-5-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lawncroft, Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Linwood, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald P. De</u> ADDRESS <u>Elkton, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Clifford S. Hines</u>	

PIPPIN FUNERAL HOME

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

County

Maryland

Final - Burial, No.

Section

of

Godsland Road, District, No.

Interment No.

Final - Burial, No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File (pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4456

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64425

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>4 minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East Rural</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Jefferson</u> Last <u>Spotswood</u>				4. DATE OF DEATH Month <u>4</u> Day <u>17</u> Year <u>19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-7-1912</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>17</u> Hours <u>19</u> Min. <u>60</u>		IF UNDER 24 HRS. Months <u>4</u> Days <u>17</u> Hours <u>19</u> Min. <u>60</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House painting</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph A Spotswood</u>				14. MOTHER'S MAIDEN NAME <u>Susan Spotswood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-07-5978</u>		17. INFORMANT <u>Mrs Ruth Boulden Spotswood North East, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO <u>Cardiac infarction</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cardiac infarction</u> (c) <u>Cardiac infarction</u> DUE TO <u>Cardiac infarction</u> (c) <u>Cardiac infarction</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac infarction</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R. C. Dodson</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>April 18, 1960</u>	
EXAMINER'S NAME (Type) <u>R. C. Dodson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-20-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosebank</u>		22d. LOCATION (City, town, or county) (State) <u>Calvert, Cecil Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>				ADDRESS <u>North East, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>APR 21 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Robert S. Grant</u>	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MINISTER		17. SIGNATURE OF CLERGY		18. SIGNATURE OF CHURCH	
19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF BURIAL		21. SIGNATURE OF CREMATION	
22. SIGNATURE OF INTERMENT		23. SIGNATURE OF REINTERMENT		24. SIGNATURE OF REINTERMENT	
25. SIGNATURE OF REINTERMENT		26. SIGNATURE OF REINTERMENT		27. SIGNATURE OF REINTERMENT	
28. SIGNATURE OF REINTERMENT		29. SIGNATURE OF REINTERMENT		30. SIGNATURE OF REINTERMENT	
31. SIGNATURE OF REINTERMENT		32. SIGNATURE OF REINTERMENT		33. SIGNATURE OF REINTERMENT	
34. SIGNATURE OF REINTERMENT		35. SIGNATURE OF REINTERMENT		36. SIGNATURE OF REINTERMENT	
37. SIGNATURE OF REINTERMENT		38. SIGNATURE OF REINTERMENT		39. SIGNATURE OF REINTERMENT	
40. SIGNATURE OF REINTERMENT		41. SIGNATURE OF REINTERMENT		42. SIGNATURE OF REINTERMENT	
43. SIGNATURE OF REINTERMENT		44. SIGNATURE OF REINTERMENT		45. SIGNATURE OF REINTERMENT	
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49. SIGNATURE OF REINTERMENT		50. SIGNATURE OF REINTERMENT		51. SIGNATURE OF REINTERMENT	
52. SIGNATURE OF REINTERMENT		53. SIGNATURE OF REINTERMENT		54. SIGNATURE OF REINTERMENT	
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61. SIGNATURE OF REINTERMENT		62. SIGNATURE OF REINTERMENT		63. SIGNATURE OF REINTERMENT	
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91. SIGNATURE OF REINTERMENT		92. SIGNATURE OF REINTERMENT		93. SIGNATURE OF REINTERMENT	
94. SIGNATURE OF REINTERMENT		95. SIGNATURE OF REINTERMENT		96. SIGNATURE OF REINTERMENT	
97. SIGNATURE OF REINTERMENT		98. SIGNATURE OF REINTERMENT		99. SIGNATURE OF REINTERMENT	
100. SIGNATURE OF REINTERMENT		101. SIGNATURE OF REINTERMENT		102. SIGNATURE OF REINTERMENT	



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**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**4478**  
**CERTIFICATE OF DEATH**

64427

1. PLACE OF DEATH a. COUNTY <b>CECILL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PERRY POINT</b>		c. LENGTH OF STAY IN 1b <b>1month27days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>331 E. Lorraine Avenue</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>LEROY</b> Last <b>WAGNER</b>		4. DATE OF DEATH Month <b>April</b> Day <b>11</b> , Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1921</b>
9. AGE (In years last birthday) yrs. <b>38</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>10</b> Hours <b>14</b> Min. <b>4</b>	IF UNDER 24 HRS. Months <b>3</b> Days <b>10</b> Hours <b>14</b> Min. <b>4</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brakeman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>IRVIN L. WAGNER</b>	
14. MOTHER'S MAIDEN NAME <b>AGNES CONNOLLY</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>Yes</b>	
16. SOCIAL SECURITY NO. <b>WW-II</b>		17. INFORMANT <b>Mrs. Marie Wagner, 331 E. Lorraine Ave., Balto. Md. (Ste-Mother)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pyonephrosis, secondary to urinary obstruction</b> DUE TO <b>199.2</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized carcinomatosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b> <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonitis, lobar, bilateral, organism unknown</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>February 15, 1960</b> to <b>April 11, 1960</b> , that (1) (we) lost saw the deceased alive on <b>April 11, 1960</b> , and that death occurred on <b>April 11, 1960</b> at <b>9:05AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>A.A. Bernardo</b>		22b. DATE SIGNED <b>4-13-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>A.A. BERNARDO Chief, Resident, Surgical Service, VAH, Perry Point, Md.</b>		22d. ADDRESS <b>Baltimore, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>4/13/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>	23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>PENNINGTON &amp; SON</b>		25a. REC'D BY REGISTRAR <b>Havre DeGrace, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>APR 18 '60</b>		25c. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

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4457

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frank Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. LENGTH OF STAY IN 1b <b>20 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CLYDE COLUMBUS WEDDLE</b>				4. DATE OF DEATH Month Day Year <b>April 1, 19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>15 Feb 1915</b>	
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner &amp; Operator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Cos C. Weddle</b>				14. MOTHER'S MAIDEN NAME <b>Mazie V. Rice</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-10-1190</b>		INFORMANT <b>714 Trail Ave., Mrs. Mazie V. Weddle, Frederick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2. RUPTURED GASTRIC ULCER</b> DUE TO (b) <b>1. FECAL FISTULA</b> DUE TO (c) <b>3. PARTIAL INTESTINAL OBSTRUCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. INTERVAL BETWEEN ONSET AND DEATH <b>ONE MONTH</b> <b>3 weeks</b> <b>3 weeks</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>March 8, 1960</b> , to <b>April 1, 1960</b> , that I last saw the deceased alive on <b>April 1, 1960</b> , and that death occurred at <b>8:00 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>1 Apr 1960</b>							
ACTUAL SIGNATURE <b>Henry V. Davis</b> M.D.							
PHYSICIAN'S NAME (Type) <b>HENRY V. DAVIS M.D.</b>				<b>@ HESAPEAKE CITY MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-4-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S NAME (Type) <b>W. B. Harrison &amp; Son, Frederick, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 4 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4458

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64429

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lanar Richard Wehry</b>		4. DATE OF DEATH Month Day Year <b>4 30 19 60</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-19-1947</b>
9. AGE (In years last birthday) <b>13</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <b>School Boy</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Pottsville, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Willard Wehry</b>		14. MOTHER'S MAIDEN NAME <b>Catherine A. Ringenary</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Willard Wehry, Rising Sun, R.D.1. Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture second dorsal vertebrae with</b> <b>817X</b> DUE TO <b>severance of spinal cord.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>abrasion and contusions right side of body</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Riding a bicycle and was hit by car</b>	
20c. TIME OF INJURY Month, Day, Year <b>7:10 p.m. 4 30 60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>County Rd.</b>		20f. (City or town) (County) (State) <b>Rising Sun, R.D. Cecil Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>R.C. Dodson</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/5/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rising Sun Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Theron E. M. Mullen</b>		ADDRESS <b>Rising Sun Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 3 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records prior to burial, cremation, or removal.





TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

64430

4459

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Locust Point	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hos pital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Taylor Last Wollaston		4. DATE OF DEATH Month 4 Day 7 Year 60	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-2-1906
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Tires	11. BIRTHPLACE (State or foreign country) Delaware
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William T. Wollaston		14. MOTHER'S MAIDEN NAME Maud Y oung	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 222-05-7760	
17. INFORMANT Mrs. W.T.Wollaston, Locust Point, Elkton, R.D.Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cor onary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 minutes			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C.Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 4-7-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 11, 1960	
22c. NAME OF CEMETERY OR CREMATORY White Clay Creek		22d. LOCATION (City, town, or county) (State) Newark, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE K.T. Jones		ADDRESS Newark, Del.	
24a. REC'D BY REGISTRAR DATE APR 12 '60		24b. REGISTRAR'S SIGNATURE C. L. Jones	

MEDICAL CERTIFICATION

